GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Caylee Noggle, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM
EMPLOYER HEALTH INSURANCE DATA FORM

Employee:_____ Social Security #:_____

Please provide the following information. See Page 2 for address, fax number, and email address.

1. Please attach a copy of the **2022** Benefit Rate Sheet to this form.
2. Name of plan the employee has chosen _____.
3. Number of employee pay periods for **2022** _____.
4. Number of times the premium will be deducted from employee's paycheck in **2022**_____.
5. Amount of the premium you (**the employer**) are responsible for paying per pay period $_____. **(Please do not include a percentage)**
6. Amount of the premium the (**employee)** is responsible for paying (medical only) per pay period $_____. **(Please do not include a percentage)**
7. Start date and end date for open enrollment _____ through _____.
8. Effective date of changes made during open enrollment _____.
9. Name of insurance carrier(s) for your company's medical benefits_____.
10. Company Federal Employee Identification Number/Tax ID (FEIN): _____. (**Must be provided)**
11. Number of individuals employed by your company: _____.
12. Is your company a state employer? Yes / No
13. Does your company reside in the state of Georgia? Yes / No

Name/Address of Insurance Carrier ***Name/Address of Employer***

_____ _____
_____ _____
_____ _____
_____ _____

Insurance Carrier Phone Number: _____

_____ _____
Policy Number Group Number

_____ _____ _____
Completed By (Employer Signature) Date Phone Number

_____
Print Name/ Employer Title

Please return completed form to:

HMS/HIPP UNIT
100 Crescent Centre Parkway
Suite 1000
Tucker, GA 30084
Phone: 678-564-1162, Option 1
Fax: 800-817-1769
Email: hippga@hms.com (for attachments PDF format is preferred)

If you have any questions, please contact HMS/HIPP Unit at 678-564-1162, Option 1.